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ABSTRACT

This paper considers the common association between marital problems and depression and describes the cognitive and behavioral factors which are common to these two problems. A set of cognitive behavioral interventions is presented, a treatment procedure which addresses cognitive and behavioral factors at the intrapersonal and interpersonal levels is described, and treatment limitations and possible solutions to problems that may arise in treatment implementation are discussed. The interventions presented, which focus on modifying spouses' distorted causal attributions, include logical analysis, review of past and current concrete evidence, and the use of behavioral experiments to test assumptions. Since treatment combines individual and conjoint sessions, strategies are given for conducting each type of session. Specific therapeautic issues and procedures for use with depressed and nondepressed spouses are described. Methods of reducing clients' tendencies to view their marital problems in terms of unidimensional causality is reviewed, as are methods for modifying spouses' self-fulfilling negative prophecies about their relationship. Techniques for modifying unrealistic beliefs about individual and marital functioning are outlined. Possible solutions to common problems such as depression in both spouses, an unavailable partner, chronic aversive marital interaction, and problematic therapist characteristics are presented. (Author/ABB)

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Cognitive Behavioral Marital Therapy in the Treatment of Depression

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Cognitive Behavioral Marital Therapy in the Treatment of Depression

Abstract

A growing body of research findings has indicated a common association between marital problems and depression. Regardless of the initial causal process accounting for this association, there are many cognitive and behavioral factors common to the two problems. This paper describes these factors and a set of cognitive behavioral interventions designed to modify them. Assessment and treatment consist of a combination of individual and conjoint sessions. Specific therapeutic issues and procedures for use with depressed and nondepressed spouses are described. Interventions focused on modifying spouses' distorted causal attributions include logical analysis, review of past and current concrete evidence, and the use of "behavioral experiments" to test assumptions. This paper also reviews methods for reducing clients' tendencies to view their marital problems in terms of unidirectional (versus circular) causality, and for modifying spouses' self-fulfilling negative prophecies about their relationship. Techniques for modifying unrealistic beliefs about individual and marital functioning are outlined as well. Possible solutions to common problems such as depression in both spouses, an unavailable partner, chronic aversive marital interaction and problematic therapist characteristics are presented.

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There is a growing body of evidence that depression and marital problems often are associated (e.g., Bothwell & Weissman, 1977; Coleman & Miller, 1975; Hinchliffe, Hooper & Roberts, 1978; Rounsaville, Weissman, Prusoff & Herceg-Baron, 1979; Weiss & Aved, 1978). Marriages of depressed individuals tend to be characterized by a lack of mutual emotional support and intimacy, hostility, and poor skills for communication and problem-solving (Coyne, in press; Jacobson, 1984). No matter what the initial causal process accounting for this association may be, the nature of marital interaction in such relationships appears to interfere with both the resolution of dyadic conflicts and improvement in individual depression. For example, Rounsaville et al. (1979) found that marital conflict impeded response to treatment for depression.

When therapists commonly are presented with clients who report both depression and marital distress, the question of initial causality becomes less important than the identification of factors that currently link the two problems. In fact, there are many similarities between the subjective experiences of depression and marital distress, as well as the cognitive and behavioral factors implicated in the two syndromes (Epstein, 1985a). These characteristics common to depression and marital distress are listed in Table 1.

To the extent that parallel or interlocking cognitive and behavioral factors account for the maintenance of both

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depression and marital distress, a set of cognitive-behavioral interventions that addresses these factors at the intrapersonal and interpersonal levels should maximize treatment efficacy. This paper describes such a treatment, its apparent limitations, and possible solutions to problems that arise in its implementation.

Components of cognitive-behavioral marital therapy for depression.

The format of this therapy tends to call for a combination of individual and conjoint sessions. Ideally, the assessment includes an individual interview with each spouse, as well as a joint interview. The purposes of the individual evaluation sessions are to gather information about each individual's personal history (especially prior depression and past experiences in intimate relationships), each party's idiosyncratic definition of the current problem(s), possible biases in his or her cognitive processes, and strengths or problems with his or her interpersonal behavioral skills.

The conjoint assessment session is intended to provide a brief sample of marital interaction, particularly information about the types of behaviors by one spouse that are likely to elicit strong negative emotion and dysfunctional behavioral responses from the other. This interaction sample is used only to form initial hypotheses about the interplay of the two spouses' cognitions, affects and behaviors. The couple's potential range of interaction

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also is tested by asking them to describe how they met and what initially attracted them to one another, a task that can elicit more congenial interaction in some couples. In both the individual and conjoint assessment interviews, it is important to gather information about what each spouse originally expected the marriage to be like, because failure of the relationship to meet these expectations is a common source of disappointment in distressed marriages (Ellis, 1977).

As noted by Jacobson (1984), a nondepressed partner is more likely to attend sessions if the therapist states that such involvement is for the purpose of helping reduce the other person's depression, rather than for the purpose of conducting marital therapy. Thus, care must be exercised in describing the set of individual and conjoint assessment sessions as a means of gathering all the available information that can lead to improvement in the depressed person's symptoms.

Especially if the initial referral was for individual treatment of depression, and if the "identified patient" has severe depressive symptoms, several individual therapy sessions may be needed to "socialize" the person into traditional cognitive therapy (Beck, Rush, Shaw & Emery, 1979) and produce some symptom reduction. It can be quite difficult for the depressed individual to work collaboratively with the partner in conjoint sessions when he or she is preoccupied either with negative

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self-appraisals or with blaming the partner. For this reason, the individual is given the rationale that initially the therapist wants to focus on the depression, so that symptoms that could interfere with the solution of problems in the marriage (e.g., lack of energy, a sense of hopelessness, self-criticism, indecisiveness) can be reduced. Essentially, the message given is "Let's get you in the best shape to be able to interact with your spouse effectively and make progress on the problems you see in the marriage." When both spouses are depressed, each would be seen individually for a number of sessions in this manner.

The nondepressed spouse also is likely to require some individual sessions to deal with his or her emotional and behavioral responses to the depressed individual (e.g., rage, blaming, oversolicitousness) that maintain the depression or the marital conflict. However, when neither spouse is severely depressed and both are judged to be capable of listening to each other, conjoint sessions may begin soon after the initial evaluation interviews. The joint sessions then can be mixed as needed with individual cognitive therapy sessions, particularly for the depressed person. Again, individual sessions are recommended to a nondepressed spouse as a means of helping him or her cope with and reduce the partner's depression.

Strategies for individual sessions. Individual sessions with a depressed spouse involve traditional cognitive therapy interventions. The client first is coached in

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identifying specific daily life events that elicit increases and decreases in level of depression. This survey of eliciting events can focus on marital interactions, but the therapist encourages the client to include any other events that affect mood states negatively. Not only does this aid the therapist in determining the range of factors contributing to an individual's depression, but it also provides valuable data the therapist can use to illustrate for a client when his or her depression is a response to a variety of events, rather than only to the partner. These data can help counteract the client's tendency to blame the partner for his or her distress.

The client is coached in use of the Daily Record of Dysfunctional Thoughts (Beck et al., 1979), which includes columns for recording a concrete description of an upsetting event, the mood(s) elicited by that event, and the person's automatic thoughts at that moment. The therapist describes a cognitive mediation model of depression, in which a person's emotional and behavioral responses to a situation depend on the meaning that he or she attaches to it. It is stressed that automatic thoughts be recorded verbatim as the client experiences them in a situation, because one can only test their validity if one knows their specific content.

The client also is taught about the cognitive distortions (e.g., arbitrary inference, selective abstraction, all-or-nothing thinking) identified by Beck (1976; Beck et al, 1979) and is aided in spotting these

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biases in his or her automatic thoughts. It is important that the therapist not convey the idea that the client's negative view of the partner is unfounded, but instead it should be stated that what is important in marital conflict resolution is the empirical testing of any hypotheses the client has. The therapist also notes that any cognitive appraisals that elicit extreme responses, including depression, will be likely to interfere with the client's effectiveness in achieving desired changes in the marriage. Thus it is to the client's advantage to learn to respond in a more measured manner when dealing with the partner.

On the therapist's part, it is important to distinguish as best one can between automatic thoughts that are biased by cognitive distortions and those that reflect accurate perceptions of negative marital interactions. In marital therapy, reality testing often can lead to interventions designed to modify actual aversive behavior on the partner's part.

Central among the distortions in automatic thoughts that have been implicated in both depression and marital distress are biased causal attributions. Depressed and maritally distressed individuals both tend to attribute negative events to global, stable causes, and positive events to specific, unstable causes, compared to nondepressed and nondistressed people (Epstein, 1985a). Also, maritally distressed spouses tend to attribute marital problems to malicious intent and lack of love on the part of their

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partners (Pretzer, Epstein & Fleming, 1985). Consequently, potential biases in clients' attributions become important targets of cognitive restructuring, with a focus on how misattributions can be shaped by systematic cognitive distortions such as arbitrary inferences and overgeneralization. In cognitive therapy with clients who are both depressed and maritally distressed, the therapist intervenes in a manner that helps members of the couple counteract attributional biases that contribute to the two problems simultaneously.

One major means for helping the client test the validity of attributions and other automatic thoughts is logical analysis (e.g., does an arbitrary inference actually make sense?). Another is review of data from past experiences, or ongoing logs of present events that will support or refute the appraisal (e.g., do the facts about the partner's concrete behavior support the inference that he or she has an invariant "trait" of selfishness, or does the person's behavior vary from selfish to unselfish acts across different situations?). An important third method is the design of "behavioral experiments" with which the client tests a potentially distorted appraisal. For example, depressed clients often use their symptoms of fatigue and low mood as "evidence" that they cannot carry out even minimally demanding daily tasks, and they attribute their difficulty to a stable, internal depletion of their resources. This attribution often is counteracted in

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cognitive therapy by suggesting that it may represent the cognitive distortion of emotional reasoning, and then encouraging the client to experiment with performance of particular tasks even when depressive symptoms "tell" him or her that the task cannot be accomplished. If the therapist has selected a task with a good probability for success, the resulting data can weaken the client's negative attribution.

In couple's therapy, behavioral experiments can be designed to counteract negative attributions the spouses have about the causes of their marital problems, as well as about one spouse's depression. On the one hand, if a person attributes the couple's poor communication to the partner having a trait of egocentrism ("All he can think about is himself"), this inference can be tested by coaching the pair in expressive and listening skills (e.g., Guerney, 1977). For some spouses, the trait attribution is modified when they see that their partners have the motivation and ability to understand their messages (Epstein, 1985b).

On the other hand, a depressed and/or distressed spouse's negative trait attribution may be concerned with his or her own responses within the marriage. It is common for spouses in these dysfunctional relationships to report "I don't feel love for him the way I used to, so the marriage must be dead, and why try?" If the therapist were to debate this interpretation with the client, the power of the "emotional reasoning" would be likely to leave the client perceiving a lack of empathy from the therapist.

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Instead, it is helpful for the therapist to express an understanding about the disappointment and concern that must be generated when the client experiences this marked drop in positive feelings for the partner. Then the therapist can say that because the status of the marriage has been in question, it makes sense to take a very careful look at the factors that have led to the shift in feelings. The therapist can describe the behavior exchange model of marital satisfaction (e.g., Jacobson & Margolin, 1979), explaining that positive feelings naturally erode when spouses experience an accumulation of negative events between them, and that shifts in the ratio of positive to negative events often gradually restore satisfaction. It is important at this point to stress that it is impossible to predict whether or not such a positive shift would take place between these two partners, but that a series of behavioral experiments can help answer the question. Client resistance to experiments often is reduced when the therapist emphasizes that they are not designed to prove the viability of the marriage, but rather to provide evidence that may be consistent or inconsistent with a spouse's attributions about his or her current level of affection for the partner.

The significance of negative attributions in depression and marital distress stems from their association with clients' perceptions of hopelessness and helplessness about their problems (Doherty, 1981; Epstein, 1985a). Attributing

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negative life events (including unpleasant marital interaction) to global, stable traits, malicious intent, and partners' lack of love is likely to be associated with low expectancies of efficacy in producing positive change. Couples who tend to apply such attributions to both problems of depression and marital conflict may be less likely to attempt active problem-solving or be motivated for therapy. A major early task of therapy is to counteract both parties' hopelessness about the depressed spouse's depression and about the longstanding repetitive pattern of aversive marital interaction. In both areas, the spouses need an increased sense of hope for change and a perception that they have abilities to make such changes.

Because hostility also is common in marriages of depressed persons (Arkowitz, Holliday & Hutter, 1982; Coyne, in press), modification of those attributions associated with anger (e.g., partner's malicious intent) also can be helpful in reducing distress. Testing whether the evidence may support an alternative explanation for the partner's negative behavior ("re-attribution"), by means of logical analysis or behavioral experiments, is the major strategy.

The hopelessness and helplessness experienced by depressed and distressed spouses also often appear to be tied to clients' tendencies to conceptualize their problems in terms of unidirectional causality. A nondepressed spouse whose many attempts to influence his or her partner's depressed behavior have been unsuccessful is likely to

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attribute the problem to stable causes within the partner. The depressed partner may perceive similar causes within the self, or may attribute the depression to an unsatisfying marriage. In either case, it is important to demonstrate for the spouses how their interactions occur in cyclic patterns, and to propose ways in which they can alter such patterns by shifting their own part in the cycle.

For example, one highly depressed woman repeatedly described increases in her depression whenever she asked her husband for attention and he failed to respond. Typically, she would react with outbursts of anger, to which he usually responded by withdrawing further. Later, the client's husband became more attentive to her as her intensified depression became more evident. This "good" period lasted for a while, before his attentiveness decreased and the cycle started again. The client attributed the problem to her husband's personality ("a workaholic") and a lack of love for her. When these events and her accompanying mood shifts were graphed as a sine wave on a blackboard, the client became aware that her outbursts actually intensified her husband's withdrawal and her own depression. She agreed to experiment with more constructive ways of drawing his attention and simultaneously worked to counteract negative automatic thoughts (e.g., "He works to avoid me") that exacerbated her distress. This strategy demonstrated to her that she was not helpless to influence her depression or her husband's behavior. She became less depressed, and he

withdrew less as her outbursts decreased.

Depressed and distressed spouses also tend to hold problematic expectancies about probabilities that their partners will respond to them in particular ways (Epstein, in press). When expectancies are accurate, they are functional in relationships, because they allow spouses to predict future behavior, based on past experiences. For example, if one's goal is to resolve a conflict with one's partner, it is useful to know that the partner is likely to react poorly to a particular negotiation strategy. In contrast, when a person's expectancies about the partner are distorted (often by the cognitive distortions described by Beck), the individual may become inhibited, defensive or aggressive in anticipation of a negative response that in fact would not occur. This behavior may in turn produce a self-fulfilling prophecy by eliciting a negative response from the partner similar to the one that had been anticipated. Consequently, it is important for the therapist to identify negative expectancies that the depressed and nondepressed spouses hold and guide the couple in testing their validity, using the methods described earlier.

Cognitive therapy focuses not only on clients' stream-of-consciousness automatic thoughts, but also on cognitive schemata or basic beliefs a person holds, which underlie the content of his or her automatic thoughts. These schemata include unrealistic or extreme beliefs about individual functioning, similar to Ellis' (1962) concept of

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irrational beliefs, and beliefs about the nature of intimate relationships (Epstein & Eidelson, 1981). The content of a depressed or maritally distressed client's underlying beliefs can be deduced from repetitive themes in his or her automatic thoughts about distressing events, or by means of sequential questioning in which the therapist keeps responding to a client's automatic thought with a query of the form "And if that were true, what would its significance be?" This procedure often identifies a "bottom line" belief that a spouse has about the marriage (e.g., "If you cannot get all your needs met in your marriage, the relationship is defective."). Clients' extreme beliefs have been implicated in both depression and marital distress (Epstein, 1985a), so it is important for the therapist who works with such couples to identify and modify spouses' beliefs that may contribute to the two problems simultaneously.

Depressed spouses often hold extreme beliefs about their own functioning (e.g., "If I am not perfect, I am worthless," "If everyone does not approve of me, I am worthless."), about their spouse (e.g., "She has no right to behave in ways that disappoint me."), and about marriage (e.g., "Overt disagreement between spouses is a sign of a bad marriage."). A nondepressed but distressed spouse also is likely to hold unrealistic beliefs about the self (e.g., "I should be able to end my partner's depression by cheering him up or convincing him that he should not be so upset."), the partner (e.g., "People who cannot overcome their own

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problems deserve to have them."), and relationships (e.g., "Once a relationship has gone bad, it can't be changed."). The therapist's goals are to help the spouses identify beliefs that contribute to depression and marital distress, to devise modified standards that are more realistic, and to leave the couple with skills for conducting this process on their own in the future.

Techniques for changing beliefs include logical analysis, examination of evidence (from memories of past events and logs of present events) that supports or refutes a belief, and the use of behavioral experiments to produce additional data about the validity of a belief. An additional procedure is for the therapist to collaborate with the client in listing and prioritizing specific advantages and disadvantages of living according to a particular belief. The therapist can stress that even though the client recognizes the extreme nature of a belief, he or she may continue to hold it unless the disadvantages clearly outweigh the advantages. Only then will the client be likely to consider behaving according to a modified belief

Strategies for conjoint marital therapy sessions. Conjoint sessions can be used to promote both behavioral and cognitive change. When spouses are able to listen to one another without major disruptive emotional and behavioral reactions, the therapist can conduct many of the cognitive interventions described above with both people present. This format gives each spouse an opportunity to gain

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insight into the other's subjective world and a chance to learn more about cognitive processes by watching the therapist interact with his or her partner.

Conjoint sessions also allow the therapist to work with the sequential interaction of the two spouses' cognitions and behaviors. For example, the therapist can interrupt an escalating argument and help the couple identify how each spouse's cognitive appraisal of the other's behavior produced subsequent behavior that in turn was appraised by the other in a manner that led to reciprocal negative behavior. It is useful to diagram such sequences on a blackboard for the couple, especially to illustrate circular causality. In order to minimize the clients' defensiveness during this procedure, the therapist periodically can repeat the rationale that in order to reduce their unpleasant interactions with one another, it is important to examine how the intensification of their conflict is tied to the particular ways in which they interpret each other's behavior. The emphasis is on the goal of reducing their distress.

Spouses can provide data during conjoint sessions to challenge each other's negative attributions, expectancies and unrealistic beliefs. However, depressed and distressed spouses will not necessarily find each other highly credible sources of disconfirmatory information. Consequently, the therapist should present such data as experimental, emphasizing that it only makes sense for each spouse to

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gather as much information as possible gradually, in order to make a well documented appraisal of the validity of his or her cognitions. This stance makes the therapeutic process collaborative and can reduce client resistance stemming from a therapist's pressure to accept data that contradict a longstanding belief about the partner.

Conjoint work also affords the therapist an advantage in dealing with interlocking dysfunctional beliefs of two partners. On the one hand, two spouses can share the same unrealistic belief; for example, that disagreement is destructive to a relationship. Such a couple may have established a fairly stable marriage based on avoidance of overt conflict, but one that has led over time to a build-up of unresolved dissatisfactions (Raush, Barry, Hertel & Swain, 1974). On the other hand, partners may have complementary beliefs that exacerbate conflict. For example, if one spouse believes that one should be able to have all one's needs met in a marriage, and the other believes that disagreement is destructive, the former may feel frustrated and take on a pursuer role, while the other avoids overt confrontation by means of passive aggression.

In both cases, the therapist works to make the couple's respective beliefs explicit and to explore with them how the combination of those beliefs contributes to their distressing interaction pattern. Evidence about the validity of this set of beliefs, as well as their advantages and

disadvantages, can be examined with the couple just as the therapist would challenge beliefs with an individual. The therapist is responsible for maintaining a balance in his or her challenging of the two spouses' beliefs, so that the session does not deteriorate with one member of the couple attempting to prove the "crazy" nature of the other's thinking.

Conjoint sessions also provide the setting for work on the couple's dysfunctional behavioral patterns. The social skill deficits, self-control deficits, and use of aversive control found in depression and in marital dysfunction overlap considerably (Epstein, 1985a). Consequently, training in communication skills, assertive skills, and problem-solving skills can simultaneously address the behavioral deficits that limit the depressed individual's receipt of reinforcing life experiences and the parallel deficits that impede a couple's ability to resolve their conflicts. Conjoint sessions thus include assessment of behavioral excesses and deficits, followed by the use of interventions based on social learning principles (e.g., Epstein, 1985b; Jacobson & Margolin, 1979; Stuart, 1980). Cognitive and behavioral interventions commonly are integrated. For example, when cognitions (e.g., the belief that spouses should be able to mindread) interfere with clients' practice of communication skills, the therapist can use appropriate cognitive restructuring, and in turn, communication exercises can be used to produce behavioral

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data that challenge distorted cognitions.

Potential problems and solutions in cognitive behavioral marital therapy for depression

Given that the therapeutic approach described above deals with the individual issues of two spouses, plus the unique nature of the couple's interaction, using both individual and conjoint sessions, there are many opportunities for complications. The following are some common problematic situations, and some possible solutions.

Severe depression, with suicidal risk. As mentioned earlier, severe depression of one spouse calls for individual treatment that could prepare the person for conjoint work. Evaluation of the client for antidepressant medication and even hospitalization would be as is standard in individual treatment. However, the present approach often could include some individual sessions for the nondepressed partner, to modify any of his or her cognitions and behavioral responses that can maintain the other's depression as well as his or her own distress. If the partner has attributed the person's depressive behavior to negative traits (e.g, selfishness, malicious intent), the therapist can explore more benign attributions (e.g., the person has developed longstanding habits of thinking and acting in a depressive manner, but that these can be changed through a gradual re-learning process). When a partner has taken on excessive responsibility for making the other's depression disappear (e.g., "I should be able to save my

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spouse"), the therapist can work to soften this demanding belief and move the partner out of the rescuer role. This is likely to involve work with the partner's high self-expectations. When the depressed spouse has been suicidal, it is especially important to reduce the partner's belief that he or she can be responsible for the outcome. Again, such interventions are best described to the nondepressed partner as intended not as his or her own therapy, but rather to make life with the depressed person less stressful.

Because negative marital interactions often will be among the most severe stressors for the depressed spouse, any interventions in individual or conjoint sessions that modify aversive behavioral exchanges may reduce the severity of depression. Use of conjoint sessions should be based on the clinician's judgment that the depressed spouse will not be too preoccupied with hostile or hopeless thinking to have constructive exchanges with the partner.

Depression in both spouses. Most literature on depression in couples describes a pair with one nondepressed partner. Even when one spouse initially seeks therapy for depression and later the partner joins the treatment to address marital issues, at times the therapist determines that the partner is clinically depressed as well. Such a pair easily can reinforce each other's sense of hopelessness, especially about their marriage. It can be more difficult for a therapist to counteract this double

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dose of negative thinking than it is to deal with several depressed individuals in group therapy, because neither spouse is able to take the relatively detached view of the other's dysfunctional thinking that group therapy members often can achieve. Consequently, until the depressive symptoms are brought under at least moderate control, it may be necessary to conduct primarily parallel individual therapies with the two depressed spouses, with as much attention as possible to cognitive and behavioral factors that contribute to their distressing marital interactions.

When depression is simultaneously problematic and functional. At times it becomes quite clear that as distressing as a spouse's depression may be for him or her, its impact on the marriage has some positive payoffs. For example, one wife described how her husband was so depressed that he did little at home or elsewhere. An interview with the husband confirmed his depressive symptoms but uncovered the fact that they were much more severe at home than at work. At home, his depression elicited at least some nuturance from family members, and it reduced his wife's demands for his attention and considerable time investment in remodeling their house. He was quite unassertive, responding with passive aggression or depression when his wife pressured him to do something. His perception of the marriage was that he was helpless to ever change what he did not like. However, the option of becoming less depressed also was threatening, because the change would involve more

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confrontation with his wife. Consequently, he was ambivalent about working to change the unpleasant status quo.

In situations such as this, "resistance" can be conceptualized and treated in terms of cognitive variables that contribute to anxiety and avoidance of change. A client's automatic thoughts about becoming less depressed can be explored in detail, then challenged with the techniques described earlier. When the client's fears of change in the marital relationship seem to be well founded, behavioral interventions (in the above case, assertion training and problem-solving training) can be instituted.

The unavailable partner. Despite the therapist's best efforts to engage a nondepressed partner in the treatment, at times that person declines participation. The therapist still can proceed with individual therapy for the depressed spouse, emphasizing interactional patterns between this person and the partner. There is a disadvantage in not having access to the partner's cognitive material, but progress often can be made working with one member of the couple. Some reluctant partners will enter therapy when the distressed individual's aversive symptoms decrease and it is clear that the therapist has considered the depression rather than the marriage to be the problem.

It also is important to evaluate the possibility that the depressed spouse has discouraged the partner from attending therapy sessions, due to the former's concerns about the events that would take place in conjoint sessions.

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Such cognitive material (e.g., attributions about stable negative partner traits, expectancies of aversive interactions) should be explored in depth and subjected to reality testing procedures. In other words, both the depressed and nondepressed spouses are likely to exhibit some "resistance" to treatment, and the cognitive therapist approaches these responses in the same direct manner that he or she applies to any other dysfunctional client responses. The cognitive bases of the anxiety, depression, hopelessness, and avoidant behavior that often comprise client resistance are subjected to collaborative empirical tests. It is assumed that resistance will decrease when the client's accurate or inaccurate reasons for it are modified.

When evidence suggests that a client's resistance is based on an absent partner's actual aversive behavior (e.g., the partner would be likely to be highly critical of the depressed spouse during conjoint sessions), the therapist can take two approaches. On the one hand, cognitive restructuring can be used to decrease the negative impact that the aversive behavior has on the depressed person. For example, it may be that he or she is very sensitive to the partner's criticism due to a belief that others' approval is necessary in order to be a worthwhile person, or due to an expectancy that the partner's next step will be to end the marriage. On the other hand, the therapist may work to decrease the partner's aversive behavior by means of changes in the depressed spouse's own behaviors toward the partner

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(as illustrated earlier).

Counteracting negative marital history. Often spouses in marriages characterized by depression and marital distress complain of a history of aversive experiences together. The memories of unpleasant events may have eroded mutual trust significantly and in fact established "grudges." A depressed spouse may have a negative expectancy such as "She failed to meet my needs over the years, so why should I make myself vulnerable to further disappointments and pain now?" A nondepressed spouse may have a parallel expectancy such as "Every time he seems to get better and I build up my hope, he goes into another depression and it all falls apart." A cognitive therapist who is using "the evidence" to test negative cognitions can have difficulty when both members of a couple present what are to them quite impressive and bleak historical data.

It is best for the therapist to communicate empathy for the clients' past pain and then suggest the strategy of experimenting with changes in the relationship that might produce better experiences. It also is important to reduce client's self-imposed pressure for quick change by dealing with associated unrealistic beliefs, such as the idea that unless the relationship is shifted rapidly and massively, there is no hope for future satisfaction in it. The basic issue these couples face is their tendency to predict future interactions from past ones. The therapist's job is to help them suspend judgment until the predictions are tested

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adequately.

Problematic therapist characteristics. A "countertransference" problem can arise if a therapist tends to sympathize more with one of the spouses than with the other. This might involve extra concern for a depressed and possibly suicidal individual, or extra sympathy for a nondepressed spouse who has suffered through a partner's major depressive episodes over the years. These couples indeed have endured much distress, but their chances for improvement are likely to be greater if the therapist maintains a balance in his or her interventions with the two parties. Systems theory concepts, which emphasize the interdependence of two spouses' responses, are helpful in guiding therapeutic strategies. When a therapist discovers that he or she is siding with one spouse or the other, it is important to examine one's own cognitions about relationship issues that may be influencing one's reactions to the couple. These may include beliefs about how a relationship should be, as well as biased attributions and expectancies.

The therapist's own dysfunctional beliefs also can lead him or her to attempt to take over the role of one of the spouses. Most commonly, a therapist believes it is his or her duty to nurture and save a depressed individual, and this leads to overprotective behavior that essentially displaces the partner. Another difficulty therapists working with these couples often face is the ease with which one can be caught up in a couple's hopelessness about depression

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TABLE 1

SIMILARITIES BETWEEN DEPRESSION AND MARITAL DISTRESS

I. SUBJECTIVE EXPERIENCES
   A. LOW RATIOS OF POSITIVE TO NEGATIVE EXPERIENCES
   B. NEGATIVE EMOTIONAL STATES AND LOW MOTIVATION
      1. LOW MOOD, ANGER, FRUSTRATION, FEELINGS OF INERTIA
      2. LOSS OF INTEREST AND MOTIVATION FOR ACTIVITIES, WISH TO "END IT ALL"
   C. PERCEIVED HELPLESSNESS AND LOW EFFICACY IN INFLUENCING DISTRESSING EVENTS AND FEELINGS
   D. HOPELESSNESS ABOUT THE QUALITY OF FUTURE EVENTS

II. BEHAVIORAL FACTORS INFLUENCING DEPRESSION AND MARITAL DISTRESS
   A. SOCIAL SKILL DEFICITS
      1. COMMUNICATION SKILLS (E.G., EXPRESSIVE & LISTENING SKILLS)
      2. ASSERTIVENESS SKILLS
      3. PROBLEM-SOLVING SKILLS
      4. SKILLS FOR MANAGING TIME AND SCHEDULING POSITIVE ACTIVITIES
   B. SELF-CONTROL DEFICITS
   C. USE OF AVERSIVE CONTROL (WITH SELF OR PARTNER)

III. COGNITIVE FACTORS INFLUENCING DEPRESSION AND MARITAL DISTRESS
   A. NEGATIVE TRACKING AND GLOBAL NEGATIVE SET
   B. BIASED CAUSAL ATTRIBUTIONS
   C. UNREALISTIC BELIEFS

(Based on Epstein, 1985a)